The Mommies Toolkit: Improving Outcomes for Families Impacted by Neonatal Abstinence Syndrome

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The Texas Department of State Health Services

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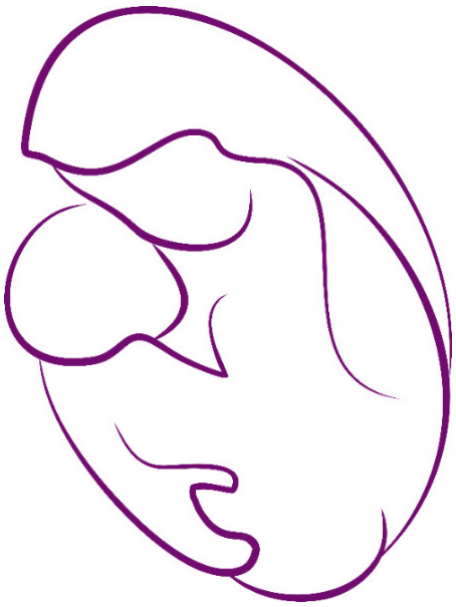

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USING THIS TOOLKIT

This *toolkit* was designed to be a resource for community agencies and partners who are interested in developing an integrated program, similar to the *Mommies Program*, for pregnant and parenting women with substance use disorders in their communities. The information was gathered from a variety of sources including publications, statewide databases, community agencies, professionals who work with the *Mommies,* and several of the *Mommies* themselves.

The primary focus of the *toolkit* is to illustrate the essential components of the *Mommies Program* to aid agencies in conceptualizing how this type of program might work in their community with an understanding that resources and the availability of key personnel may vary by location. This toolkit is meant to be used only as a guide and each agency is encouraged to modify and shape their version of the program to meet the specific needs of their community members.

Disclaimer: This toolkit does not replace training or in any way suggest a practitioner's competence or adherence to regulations and laws.

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PREFACE

This *toolkit* was created through a collaborative effort between the Texas Department of State Health Services (DSHS), The Center for Healthcare Services (CHCS), University Health System in San Antonio, and The University of Texas Health Science Center at San Antonio (UTHSCSA), School of Nursing. Funded by DSHS, our goal was to create a *toolkit* for other agencies who may wish to replicate the *Mommies Program* in their communities to improve outcomes for families who are impacted by neonatal abstinence syndrome: a constellation of withdrawal symptoms observed in infants who are prenatally exposed to a variety of substances. The *Mommies Program*, originally called *Project Carino*, was first developed in 2007 at the CHCS through federal funding with a five year, $2.5M Substance Abuse & Mental Health Services Administration (SAMHSA) grant. Due to the program's success, at the end of the funding cycle, University Health System contracted with CHCS to assist with funding and sustaining the program, renaming it the *Mommies Program.*

The annual cost for maintaining the *Mommies Program* ranges between $175,000 and $400,000, depending upon available resources. Funding comes from three primary sources: University Health System, Medicaid reimbursement for services, and DSHS as a payer of last resort. This mosaic of funding provides services to roughly 160-175 women and their children each year. To date, more than 1,000 pregnant women with substance use disorders and their infants have been served by the *Mommies Program*. The success of the program is due largely to the integrated nature of the services offered to its participants. In this *toolkit*, we will describe these services and how

community partners have worked together to integrate them. We will also share our *"words of advice"* learned during the development and administration of the *Mommies* and the many successes of this program. The information provided in this *toolkit* was written by the authors; however, all facts and details were reviewed by the community partners, discussed, verified for accuracy, and approved prior to publication.

PREFACE

Roxanne's Story

"My name is Roxanne and I have been attending the Mommies Program for almost 2 years now. When I first started, I had an open CPS [Child Protective Services] case. I had just lost my house and had no place to stay. My kids were removed by CPS and I was so lost-so close to losing my children forever. My CPS worker recommended I attend classes and the Mommies Program had those classes. I was given a counselor who helped me see things in such a positive way. She made me feel special and worthy.

"The classes helped me cope and stay clean and to be a good and supportive parent. I've learned how to handle tough situations and make positive choices. I looked forward to the classes and they actually made me want to stay sober. Before I knew it, I had my house, had completed my classes, and was able to bring my babies home. The Mommies counselors have helped me so much. It wasn't just a job to them. I felt like they were family and that they did really care about where I ended up.

"Today I still go to my Mommies classes. I've been clean since the first day of the program. Most of all I am happy to say that every morning before class, I drop my children off at the wonderful daycare at the center. I now have full custody of my babies. It's all thanks to the Mommies Program."

Roxanne, A Mommies Program participant

PREFACE

Stephanie's Story

"Hello. My name is Stephanie. I have been a part of this program…let me rephrase, ***amazing*** *program for about 2 years. In the beginning, I thought it was going to be another boring place using a bunch of big words and no feeling to what I was going through. Well, I was wrong. This program has given me a new, positive perspective on my life. It made me realize that I don't have to be alone and just become someone who gives up with no hope. I'm a bit of a skeptic so believe me when I say I didn't believe in therapy or group support. I never thought that talking about your problems or telling someone how you truly felt could be so eye-opening. I have come to understand myself and also to forgive myself for the things I've done. I no longer have to carry the weight of the world on my shoulders-thanks to this program. This is what I truly feel in my heart. Thank you for taking the time to listen to someone who thought they had no voice."*

Stephanie, A Mommies Program participant

CHAPTER 1

Substance Use Disorders

National Statistics

Substance use disorders (SUDs) are a growing public health concern in the United States. Rising SUD rates are likely related to the nationwide increase in the use of prescription opioid pain relievers (OPR's).[1]

- National sales of OPR's quadrupled between 1999 and 2010 and a trend toward the prescribing of OPR's stronger than morphine has been reported. For example, in 1999, only 17% of opioid users were using OPR's stronger than morphine, but in 2012 this number had risen to 37%.[1]
- In 2011, the Centers for Disease Control & Prevention (CDC) reported that drug overdose deaths had become the leading cause of injury death in the United States, surpassing motor vehicle accidents. [2]
- Texas ranks 44th in the nation for the prevalence of drug overdose death rates and 33rd for the number of opioid pain relievers prescribed.[3]
- Between the years 1999 and 2010, the overdose death rate in Texas increased by 78%.[3]

SUDs in Women

SUDs in women tend to be complex and highly correlated with comorbid conditions such as depression and anxiety.[4] Low socioeconomic status, domestic violence, and trauma are also common in women with SUDs.[5-6]

- More specifically, having experienced personal violence and trauma is reported by 50-90% of persons with SUDs. Individuals may attempt to relieve distress related to past traumatic events through the use of substances, or they may be more at risk for experiencing traumatic events as a result of their substance use.[7-8]
- Traumatic events occurring during childhood are strongly correlated with SUDs[9] and severity of childhood trauma is a significant predictor of SUD relapse in women attempting to recover.[10]

Gender specific studies focused on illicit substance use show that there are distinct differences between men and women with SUDs.

- For example, when compared to men, women are more likely to have chronic pain and be prescribed prescription painkillers at higher doses and for longer periods of time.
- Women are also more likely to engage in *"doctor shopping"* (obtaining prescriptions from multiple prescribers)[11] and more rapidly become dependent upon painkillers than men.[12]
- Further, women may be reluctant to seek help for SUDs due to the social stigma and fear of losing their children to Child Protective Services.[6]

SUDs in Pregnancy

The nationwide trends toward greater use of opioids (both prescribed and illicit) have inadvertently affected women of childbearing age.

- Substance use during pregnancy seems to reach peak numbers during the adolescent years occurring in approximately 16% of pregnant teens (Substance Abuse and Mental Health Services Administrations [SAMHSA]). [13]
- Between the years 2000 and 2009, national rates of maternal opioid use during pregnancy reportedly increased fivefold.[14]
- In 2009, more than 23,000 pregnant women in the U.S. were using opioids when they delivered, up 475% from 2000.[15]

CHAPTER 2

Neonatal Abstinence Syndrome

Substance use during pregnancy is associated with significant adverse pregnancy outcomes such as prematurity, low birth weight, and neonatal abstinence syndrome (NAS).[16] The term NAS is typically used to describe withdrawal that follows in-utero substance exposures, although NAS can also be *iatrogenic* in nature following the need for prolonged pain-management in critically ill infants.[14]

Symptoms

Symptoms of NAS generally include

- Irritability
- An inconsolable, high-pitched cry
- Fever
- Feeding difficulties and poor weight gain
- Vomiting and diarrhea
- Skin breakdown
- Sleep issues
- A potential for seizures
- And, in rare cases, death.[17]

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For infants who are prenatally exposed to opioids, the severity of NAS symptoms may be intensified if the infant is also exposed to opioid agonists such as cigarette smoke, benzodiazepines, and antidepressants, such as SSRIs.[18]

Incidences

Over the past decade, there has been increased national attention focused on the parallel rising trends between prescription opioid misuse and incidences of NAS.

- U.S. rates of NAS increased threefold between the years 2000 and 2009 with one child now being born every hour experiencing symptoms of NAS.[14]
- NAS can occur following exposure to a wide range of substances such as certain antidepressants, barbiturates, and nicotine; however, the most severe symptoms are typically associated with in-utero opioid exposure.
- It is estimated that 60%-94% of opioid exposed neonates will develop NAS.[19-23]
- Still, prenatal opioid exposure is considered a risk factor for but not a predictor of NAS, and neither daily opioid dose nor total dose throughout the pregnancy predicts incidences or severity of NAS.[24]

Cost

In addition to the human costs of NAS, the associated healthcare costs for providing care for infants with NAS has risen from $190M per year to $720M per year as a result of the increasing incidences.[14]

- In 2009, average hospital expenses for infants with NAS were estimated at $53,400 when compared to $9,500 for all other births.[14]

- The high cost of hospital care is primarily due to a lengthy hospital stay in a Neonatal Intensive Care Unit (NICU) and the need for extensive nursing care.[14]
- Average hospital length of stay (LOS) for newborns with NAS is approximately 16 days when compared to 3 days for all other births.[14]
- LOS for infants with NAS has not decreased during the past decade, leading experts to speculate that there may be more efficient and cost effective ways to provide care for infants with NAS.[14]
- Nationally, 78% of all NAS healthcare costs are paid for by state Medicaid programs.[14]
- NAS also results in increased costs to the Child Welfare System through investigations, removals, and placement in foster care. For example, the cost of providing foster care for one child is approximately $25,281 per year and kinship care for children placed with family is $1,500 per year.[25]

Diagnosis & Management

Management of NAS begins with making an accurate diagnosis. The first step in doing this is the careful screening of all pregnant women for SUDs.

- Following birth of the infant, diagnosing NAS may be aided through the use of blood and or urine sample screening from the mother and infant. But, this is only true if

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the substance exposure is recent. If the exposure is not recent, these tests may not be sensitive enough to detect substances.[26]

- In this case, screening of the infant's first meconium stools is more sensitive since meconium accumulates substances during the last five months of pregnancy.[27]

Assessment of the infant for signs and symptoms and severity of withdrawal is also essential in providing care for infants with NAS.

- The American Academy of Pediatrics Committee on Drugs guidelines recommends that a reliable assessment tool be used to monitor for symptoms of withdrawal, a maternal history and urine drug screening be completed, as well as screening of the infant's urine and meconium.[17]
- A variety of NAS assessment instruments are available for use by practitioners. These include the Lipsitz Neonatal Drug-Withdrawal Scoring System, the Finnegan Neonatal Abstinence Scoring Tool (FNAST), the Neonatal Withdrawal Inventory, and the Neonatal Network Neurobehavioral Scale Part II: Stress Abstinence Scale.[28]
- The FNAST is likely the most widely used instrument and has good measures of reliability (α=.82).[29] Assessment of NAS symptoms using the FNAST should occur every 3-4 hours with treatment of symptoms generally recommended for infants with a score of 8 or greater during 3 consecutive assessment periods or 2 consecutive scores of 12 or higher.[28] Inter-observer reliability is essential for practitioners who use the FNAST; therefore, the instrument's author recommends thorough and regular training of staff.

Care for infants with NAS typically involves a combination of pharmacologic (medications) and non-pharmacologic soothing strategies for the management of withdrawal symptoms.[30]

- Non-pharmacological soothing techniques such as swaddling the infant in blankets, skin-to-skin care with mother, pacifiers, rocking, low stimulation environment, small frequent feedings, and breastfeeding are the first line of treatment for NAS. [26, 30, 31]

- When NAS symptoms escalate and pharmacological interventions are warranted, medications of choice may include Neonatal Opioid Solution, morphine, methadone, or buprenorphine, which are started at low doses and slowly titrated up until control of symptoms is achieved. Infants are then gradually weaned off of these medications as their symptoms begin to resolve. Clonidine and phenobarbital may also be used as adjunct medications.[32]
- While the use of medications for infants with NAS is appropriate when symptoms are severe, statistics indicate that once medications are initiated, the infant's length and cost of hospital stay may be significantly prolonged.[33]
- Recently, a new approach to the treatment of NAS, outpatient management of symptoms using methadone, has shown promise at the University of Vermont

Children's Hospital. Benefits of this management strategy include a reduced length of hospital stay, a slower weaning process resulting in fewer NAS symptoms, family empowerment, and increased breastfeeding rates.[34]

Breastfeeding

Breastfeeding is a safe and essential component in the care of infants with NAS. In addition to the well-documented health benefits of breastfeeding to mother and child, the close skin-to-skin contact associated with breastfeeding may play a role in reducing NAS symptoms and supporting mother-infant attachment.[35]

- Methadone and buprenorphine are detected in breast milk in very low levels; therefore, the amount ingested by the breastfeeding infant is very low.
- Methadone concentrations in breast milk are unrelated to maternal methadone dose.
- Buprenorphrine can be detected in breastmilk in only small amounts 2 hours following maternal dosing.
- Several studies have shown the relationships between breastfeeding and a reduction in NAS severity and duration.
- Many experts agree that the benefits of breastfeeding outweigh the risks of infant opioid intoxication during maternal methadone or buprenorphine use.
- Hepatitis C is not a contraindication for breastfeeding.
- Maternal HIV is still considered a contraindication to breastfeeding in westernized countries.[35]

CHAPTER 3

Integrated Programs

Evidence shows that integrated treatment models (those that combine on-site pregnancy, parenting, and child-related services with addiction services) are essential for addressing the many needs of pregnant and parenting women with substance use disorders (SUDs).[36]

Components

These programs ideally combine Medication Assisted Treatment (MAT) with additional services to assist pregnant women with SUDs.

- MAT is a form of treatment for opioid dependency that includes regular (often daily) administration of medications such as methadone or buprenorphine that should not result in intoxication, euphoric effects, or sedation when administered at the optimal dose for the individual.[37]
- Instead, MAT, using longer acting opioids (methadone or buprenorphine), provides a more consistent opioid blood level, thus reducing the risk of repeated fluctuations commonly experienced with shorter-acting opioids such as heroin.[38]
- In 1998, a National Institutes of Health consensus panel recommended methadone for MAT in pregnant women dependent on opioids. It is still considered the standard of care today. [39]

- MAT is an essential component of managing opioid dependency in pregnancy as abrupt withdrawal or detox from opioids results in higher incidences of fetal death. Tapering of MAT dosing during pregnancy is associated with more frequent maternal relapse into addiction.[37]
- More than 50 years of research is now available to support the benefits and safety of methadone for opioid dependent, pregnant women.[35]
- While studies on the safety of buprenorphine use for MAT in pregnancy have been emerging and showing promising results, studies showing long-term safety have not been as extensive as with methadone. This is why methadone is still the recommended medication for MAT during pregnancy.[35]

Benefits

In addition to MAT, integrated programs offer multiple services including substance abuse counseling, mental health services, prenatal and primary healthcare, parenting classes, domestic violence prevention awareness, social services, and other support resources.[36]

- Pregnant women and mothers with SUDs in integrated treatment programs have better outcomes when compared to women participating in usual-care SUD treatment.[36]
- Participants of integrated programs express greater satisfaction largely due to a judgment-free environment.[40]
- These women also report a greater likelihood they would return to the program if necessary, a key factor in successful SUD treatment. This is

particularly true since women with SUDs can be transient and may not attend follow-up or postpartum appointments.[40]

- Due to these successes, many experts recommend this integrated program model of SUD treatment for all pregnant women as the standard of care.[41]

Of the many services that may be offered in an integrated program, behavioral health treatment is likely one of the most important[42] due largely to the high incidences of comorbid mental health conditions that occur in women with SUDs.[43]

- Infants of methadone-maintained mothers who have a mood disorder require a lengthier hospital stay when compared to mothers without a mood disorder. This lends support to including behavioral health care for methadone-maintained pregnant women and may back the integration of behavioral health services into all SUD treatment programs.[44]
- Rates of depression have been found to be higher in pregnant women with SUDs[43] when compared to pregnant women without SUDs. Based on these findings, experts recommend integrating behavioral health services into treatment models focused on this population.

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Furthermore, researchers have found the integrated treatment model to be beneficial not only to women during the prenatal period but following delivery as well. There are multiple benefits to the infant through the improvement of parenting skills and overall physical health.

- Integrated SUD treatment programs may improve long-term parenting outcomes.[33]
- The implementation of integrated programs are positively correlated with healthier babies and mothers.[45]

MAT during Labor & Delivery

While MAT plays an important role in the management of opioid dependency during pregnancy, special care must be taken during labor and delivery. [37]

- Women who are receiving MAT should be offered pain relief during labor as if they were not taking opioids because MAT ***will not*** provide adequate analgesia for labor.
- Epidural and spinal anesthesia should be offered when appropriate.
- Narcotic agonist-antagonist medications such as butorphanol (Stadol), nalbuphine (Nubain), and pentazocine (Talwin) must be avoided because they can induce an acute opioid withdrawal.
- Laboring patients receiving MAT generally require higher doses of opioids to achieve analgesia than other patients.
- In one study, following Cesarean section, women who were taking buprenorphine required 47% more opioid analgesia than women who were not taking buprenorphine, but adequate pain relief was achieved with short-acting opioids and anti-inflammatory medications.

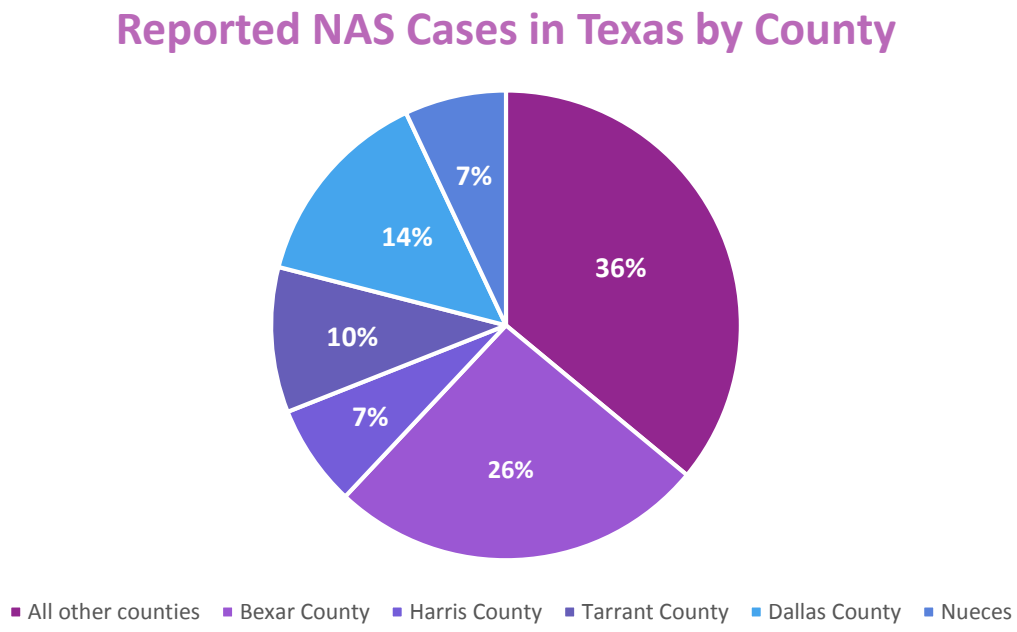
- Injectable, nonsteroidal, anti-inflammatory agents, such as ketorolac (Toradol), also are highly effective in postpartum and post-Cesarean delivery pain control.
- Lastly, daily doses of methadone or buprenorphine should be maintained during labor to prevent withdrawal, and patients should be reassured of this plan in order to reduce anxiety.[37]

CHAPTER 4

AN OVERVIEW OF THE MOMMIES PROGRAM

Texas Statistics

Following national trends, opioid use among pregnant women has increased in Texas with approximately one out of every four pregnant women admitted to the Department of State Health Services (DSHS) funded addiction treatment programs being dependent upon opioids. As a result, rates of neonatal abstinence syndrome (NAS) in Texas have increased almost 60% over the past 5 years. In 2014, Bexar, Harris, Tarrant, Dallas, and Nueces were the counties with the highest reported cases of NAS in the state of Texas with Bexar County reporting approximately 26% of all diagnosed NAS cases in the state.[46]



The Mommies Program

The *Mommies* program in San Antonio was created to address this growing concern in Bexar County. The program is currently administered through a collaborative partnership between University Health System and the Center for Health Care Services (CHCS), a Department of State Health Services (DSHS) funded Medication Assisted Treatment (MAT) program and substance use disorders treatment provider.

- *Mommies* was originally named *Project Carino* (meaning "tenderness and affection" in Spanish) and was funded for five years by a Substance Abuse and Mental Health Services Administration [SAMHSA] grant in 2007.
- Due to the success of the program, in 2013 at the end of the SAMHSA funding cycle, University Health System signed a Memorandum of Agreement with CHCS to assist with funding and sustaining the program, renaming it the *Mommies Program*.
- Annual cost for maintaining the *Mommies Program* ranges between $175,000 and $400,000 depending upon available resources.

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- This funding provides services to roughly 160-175 women and their children each year.

- There are 3 primary sources of funding for the *Mommies Program*: University Health System, Medicaid reimbursement for services, and DSHS as a payer of last resort.
- Eligible participants are pregnant CHCS consumers with ***any type of diagnosed substance use disorder*** (SUD).
- University Health System's hospital staff members (nurses and nurse practitioners, lactation consultants, physical therapists, etc.) provide educational classes at the CHCS for *Mommies* who choose to participate. This presents the *Mommies* with an opportunity to become familiar with the hospital staff they may encounter at the time of delivery and during their infant's hospital stay.

The Curriculum

The curriculum offered by the University Health System staff consists of educational sessions covering the following topics:

- Preparation for labor and delivery
- Child safety including infant CPR
- Stress management
- Nutrition
- Breastfeeding guidelines
- Shaken Baby Syndrome (SBS)
- Parenting newborns to age 3
- Tobacco exposure
- Sudden Infant Death Syndrome (SIDS)
- NAS soothing techniques and non-pharmacologic interventions

- Infant massage
- Home safety
- Domestic violence prevention
- Family planning
- Neonatal Intensive Care Unit (NICU) experience

Outcomes

Participation of women in the *Mommies Program* has resulted in a 33% reduction in infants' NICU length of stay due to NAS. In 2014, there were 1,132 infants born in Texas with NAS of which 865 (76%) required hospitalization in a Neonatal Intensive Care Unit (NICU). With an average Medicaid cost of $1,246 per infant per day for NAS related hospital expenses, this amounts to significant cost savings.[47]

CHAPTER 5

"I don't have a fancy title or many letters after my name. I have more personal experience with addiction and the impact it had on me as a child. I wish there could have been a program like this for my mother growing up. Instead there were prisons which only leave children abandoned and the family never truly recovers. The cycle repeats itself and it is very sad. This is why I chose to pursue this path and wanted to make a difference. It has also helped heal me in many ways.

"I can say that what I believe to be most helpful in working with these women is having true compassion and being able to put myself in their shoes. These women have been judged by society and come to us broken. We offer them a sense of hope for a meaningful life and teach them how to be better mothers and stronger women. We do this slowly and with great love and support. We restore their faith in humanity by letting them know there are people who genuinely care for them. And, we have to be patient and understand these women have been through hell and back. It takes time to build that trust and rapport. I remind these women that the pain doesn't have to consume them. Recovery is possible and they deserve to be happy and loved. I don't treat them like addicts. I treat them like people who are looking for help and direction. It's important to address the underlying trauma many of these women have experienced…to let them tell their story. Some women have never done that and it's where the healing begins. Mothers love their children and want to do the right thing. They need support to do it. Our program offers this to them and teaches them the skills to make positive lifestyle changes."

Alice Santacruz, LCDC, Program Supervisor, Mommies Program

KEY COMPONENTS OF THE MOMMIES PROGRAM

The foundation of the *Mommies* program is the coordination of wrap-around services to support pregnant and parenting women with any type of Substance Use Disorder (SUD); ***no diagnoses are excluded***. The program is designed to eliminate as many potential barriers as possible in order to maximize a woman's chances for successful

recovery. Care is delivered in a collaborative, non-punitive, therapeutic manner that aims to support women who seek treatment and focuses on the best interests of the women. Collaboration also occurs between other service-providing agencies that may be working with the *Mommies* such as the Adult Probation Department and The Department of Family and Protective Services (Child Protective Services).

Convenient, Centralized, Location of Services

Assistance services are made available to the *Mommies* in one centralized location: The Restoration Center at the Center for Healthcare Services (CHCS), which is the local mental health authority for the city of San Antonio, Texas.

- Located in downtown San Antonio, the CHCS operates a methadone clinic where *Mommies* with opioid dependency can be stabilized and maintained on methadone throughout their pregnancy and following delivery if needed.
- Methadone is free of charge to the *Mommies* through a combination of funding sources that include University Health System, Medicaid, and the Texas Department of State Health Services (DSHS).
- The Restoration Center also houses the Opioid Addiction Treatment Services (OATS)-Outpatient Clinic, Residential and Ambulatory Detoxification Services, the Substance Abuse Public Sobering Unit, the Crisis Care Center, and primary healthcare services. Therefore, if at any

"Partner with multiple funding streams in the healthcare industry to not only ensure sustainability but protect the highest quality of healthcare delivery. Stay focused on the vision and passion of serving this vulnerable population."

Briseida Courtois MSSW, LCDC, Director of Addiction Treatment Services, Center for Health Care Services, San Antonio, TX

time a *Mommies* participant is in need of these additional services, they are within close proximity and easily accessible.

Free Transportation, Childcare Services, and Benefits Coordination

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- Transportation to and from the center is provided by a van designated for the *Mommies* program. This van was purchased with funds from the original Substance Abuse and Mental Health Services Administration (SAMHSA) grant in 2007.
- Women who are willing and able to use public transportation are provided with free bus passes.
- Free on-site childcare is provided for the *Mommies* while they are receiving counseling, support services, and attending classes.
- A benefits coordinator (BC) is on location five days a week through the OATS program and can assist women with enrollment in healthcare and other benefits, referrals for prenatal care, and scheduling appointments.

Qualified, Credentialed Staff

- A Medical Director with specialized training in SUDs oversees all SUD services at the CHCS.
- The center is staffed by Licensed Professional Counselors (LPCs) and Licensed Chemical Dependency Counselors (LCDCs) with special training in the treatment of SUDs in women and during pregnancy. LPC's focus on and provide services

related to mental health issues, family and trauma while LCDC's provide services related only to substance abuse and dependency. Having this combination of credentials and training within one center is helpful in addressing the needs of consumers and their families in a cost-effective manner.

- At one time, the *Mommies Program* was also staffed with an Outreach Specialist and a Case Manager; two positions that are considered essential to the success of the program. However, due to budget constraints, it became necessary to eliminate these positions and reallocate their responsibilities to other program staff.
    - The role of the Outreach Specialist was to provide home visits for *Mommies* who had "dropped-out" of treatment or had not been heard from for an extended period of time. This individual required extensive knowledge of the community and the population being served.
    - The role of the Case Manager was to provide intensive case management services that included orchestrating staffing and resources between multiple agencies to ensure that consumers received the services they needed. The Case Manager was also responsible for ensuring that key individuals were present during meetings about the *Mommies* as well as providing family and consumer education about Medication Assisted Treatment (MAT) and establishing "buy-in" from family members.

Patient Navigator

As participants in the *Mommies* program, women have access to a patient navigator (PN) who is provided through funding from University Health System. Some overlap

exists between the role of the BC and the PN, but the PN's primary role is to serve as an advocate for the *Mommies* as they interface with other services or referral agencies including the woman's obstetrician and the hospital and Neonatal Intensive Care Unit (NICU) staff. The PN's role is to

- Communicate the *Mommy's* history to University Health System obstetrical staff within the Labor & Delivery Unit prior to her arrival on the unit. This information includes number of previous pregnancies and deliveries, any illnesses that may have occurred during the pregnancy, dosage of methadone the *Mommy* is taking and any issues she may be experiencing.
- Send out a brief overview of the *Mommy's* progress within the program to all essential staff (social services, child health and safety staff, maternal/newborn nurses) who will be in contact with the *Mommy* during her stay at University Health System.
- Act as the *Mommy's* advocate and share information with other agencies following her consent.
- Coordinate the educational sessions offered to the *Mommies* at CHCS.

In San Antonio, the role of the PN is fulfilled by a professional who has a degree in human services but a PN who has extensive knowledge and experience in (1) social services and case management, (2) community resources, (3) interfacing with other service agencies and providers such as legal services, and, (4) acting as a patient liaison may also serve in this role.

- The *Mommies* have access to the PN via her cellphone 24 hours a day 7 days a week.
- When a *Mommy* encounters an issue that she is unable to resolve independently, the PN can be contacted for assistance. For this reason, it is essential that women are paired with one individual consistently. This helps to foster the rapport that is necessary between the PN and the *Mommy*.
- The PN also serves as a coach by role modeling behaviors such as positive communication and conflict resolution to assist the *Mommies* with building these skills so they are able to advocate for themselves and their children in the future.

"It's important for Mommies to know they have someone who will listen to them 24/7. It's so much better than staying silent and experiencing a relapse. As a Patient Navigator, my role is to listen rather than to talk."

Yvonne Chavez-Garza, Patient Navigator, University Health System

Individualized Services and Monitored Progress

- Each woman who participates in the *Mommies* program receives counseling and an individualized plan of care that is developed by an LPC or LCDC, reviewed with the *Mommy,* and updated at the mid-point of her treatment and/or based on her individual needs. The *Mommy* signs the plan and receives a copy of it.
- The *Mommies* program offers multiple different services to assist women during their recovery. These services include (1) counseling specific to substance abuse, (2) 24-hour-a-day crisis intervention services, (3) case management, (4) individual therapy, (5) family therapy, and (6) open group therapy.
- Urine analyses (UAs) are conducted weekly through Child Protective Services (CPS), the OATS program or other agencies for *Mommies* receiving methadone

services. The results of the UAs are discussed with the *Mommies* in a therapeutic manner and used to monitor their progress in the program.

Specialized Services

Specialized services are offered to the *Mommies* based on their identified needs.

These services are delivered through the use of evidence-based curricula that include: (1) Trauma Recovery and Empowerment Model (TREM)[48] (2) Seeking Safety,[49] (3) Nurturing Parenting Program®,[50] (4) The Matrix Model,[51] (5) Life Skills Training,[52] and (6) HIV testing and education.

Trauma Recovery and Empowerment Model (TREM)

- *TREM*[48] is an evidence-based intervention designed to facilitate trauma recovery among women with a history of exposure to sexual and physical abuse.
- All center counselors who work with *TREM* have received specialized training in the use of this model which draws on cognitive restructuring and psychoeducational and skills-training techniques.
- The gender-specific, group sessions emphasize the development of coping skills and social support as well as the short-term and long-term consequences of violent victimization, including mental health symptoms especially posttraumatic stress disorder (PTSD), depression, and substance abuse.
- Since the nature of *TREM* is sensitive, these sessions are closed with only individuals who have experienced trauma participating.

Seeking Safety

- *Seeking Safety*[49] is another evidence-based intervention that is present-focused and assists individuals who are seeking safety from trauma and/or SUDs.
- This intervention does not require participants to delve deeply into previous traumatic life events making it appropriate for a wide-range of participants and relatively simple to implement.
- Special training is not required to use *Seeking Safety* but training is available.

Nurturing Parenting Program®

- The *Nurturing Parenting Program®*[50] is an evidence-based, trauma-informed, parenting program and curriculum for the prevention and treatment of child abuse and neglect.

- It is recognized by the National Registry of Evidence-based Parenting Programs and Practices, a branch of the Substance Abuse and Mental Health Services Administration.
- These family-based programs are designed to be delivered in a home setting, group setting, or a combination of both.
- The curriculum is skills-focused and competency-based and is designed to focus on the different developmental ages of children.

The *Matrix Model*

- The Matrix Model[51] is an evidence-based, intensive, out-patient treatment program for alcohol and other SUDs-including methamphetamine.
- The model's instructional design helps consumers understand complex, cognitive-behavioral and clinical concepts including the "wall" of abstinence.
- The optimal length for this program is 16 weeks for intensive outpatient treatment but can be extended for 12 months to include aftercare.
- Training in the use of the model is available.

Life Skills Training (LST)

- LST[52] is a program for the prevention of alcohol, tobacco, and marijuana use and violence.
- It targets the social and psychological factors that promote substance use and other high-risk behaviors.
- LST addresses multiple risk and protective factors and teaches skills that build resilience and help young people navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences.
- This curriculum uses facilitated discussion, small group activities, and role-playing scenarios to stimulate participation and promote the development of new skills.
- Facilitator training is available but not required.

HIV testing

- Monthly HIV testing is available through the center's HIV program.
- Regularly scheduled educational presentations on the prevention of HIV and sexually transmitted infections are also offered.

Decreasing Stigma

Another key component of the *Mommies Program* is the effort that has been made to reduce the stigma associated with being a mother who has an SUD.

- Numerous in-services have been conducted for the staff of University Health System to provide education on SUDs, Neonatal Abstinence Syndrome (NAS) and best practices related to SUDs in pregnancy.
- The purpose of these educational offerings has been to create a "culture change" within the healthcare system toward a more accepting and judgment-free environment.
- For example, when a participant from the *Mommies* program is admitted to the labor and delivery unit, she is referred to as *"one of our Mommies"* rather than some of the more derogatory labels such as "the methadone mom" or the "drug mom" that mothers have reported overhearing during encounters with the healthcare field. [53]
- Additional suggestions for reducing stigmatization of women with SUDs include

"Substance use disorders in pregnant women are often met with negativity and judgement from healthcare providers. We were able to change this negativity by helping staff understand that this is a disease-not a state of mind. This one change, altered the mindset of the healthcare team and contributed to the success of the Mommies Program."

Susan Douglass MSN, RN, CEN, Director (Ret), Child Health & Safety, University Health System

- Spreading the word about NAS and SUDs through discussion sessions, printed materials, social media, and other venues.
- During the rule-setting phase prior to discussions, ask that derogatory terms not be used by group members for labeling themselves or others. This can be accomplished in a variety of ways including using "person-first" language. For example referring to someone as an individual with a substance use disorder is person-first language and is preferable to derogatory labels such as a "junkie" or a "drug addict."
- Identify notable figures and positive influences (maybe even celebrities), who have successfully abstained from substances, as role models. For example, Robert Downey Jr. had a severe SUD but was able to rebuild his career and maintain positive changes in his life.

Program Process

Enrollment in the *Mommies Program* begins with the initial consumer intake assessment. If an assessment was already completed by an LCDC when the woman was enrolled in OATS, it is simply updated by the *Mommies* staff. At this time if the woman appears to have mental health concerns, an LPC completes a mental health assessment. Although there may be a waiting list for opioid dependent individuals hoping to begin Medication Assisted Treatment (MAT), it is a federal mandate that pregnant and parenting women have priority.

- During the intake, women are given a referral to the *Mommies Program*. If they indicate that they are interested in the program, they may discuss this with the Benefits Coordinator (BC) or meet with the Patient Navigator (PN).

- Mommies are also told about the educational curriculum that is offered and on what days and times.
- Though a *Mommy* may have Child Protective Services (CPS) and probation mandates, all substance abuse and behavioral health services are voluntary.
- Also during the intake, *Mommies* sign a release of information document that allows members of the healthcare team to communicate about and coordinate their plan of care.
- At this time, a need for the various types of services already mentioned and their required frequencies are determined.
- Services are recommended, and, if accepted by the *Mommy*, she will receive assistance with making appointments and other arrangements.

CONCLUSION

The *Mommies Program* serves as an example of how the strength of a community working together can effectively address the needs of women with substance use disorders (SUDs). Preservation of the vital mother-child relationship is at the very core of serving families who have been impacted by SUDs and neonatal abstinence syndrome. The *Mommies Program* has demonstrated that when women are surrounded by the resources and support they need, successful recovery ***is*** possible and hope for the ***future*** of the family becomes imaginable.

The authors of this *toolkit* would like to thank the *Mommies*, counselors, healthcare providers, and community partners who so graciously shared their stories and wisdom. Your generosity has made it possible for other communities to benefit from the journey you have taken to create the *Mommies Program*. In doing so, the potential to help many more families who are struggling with SUDs is immeasurable.

"I am continuously amazed by the strength, courage and tenacity of the Mommies. Many have failed before but they're willingness to try again is truly inspiring. It is a very humbling and rewarding experience to work with these women."

Susan Douglass MSN, RN, CEN, Director (Ret), Child Health & Safety, University Health System

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CURRICULUM

Nutrition

Objectives:

- Identify food groups and serving sizes in the healthy plate
- Identify differences between the healthy plate and the Food Guide Pyramid
- Identify the food groups and serving sizes in the combination foods
- Illustrate a healthy plate
- Discuss alternative methods for basic meal planning
- Describe how to read a food label
- Identify the benefits of health eating, weight management and pregnancy

Materials:

1. Food Guide Pyramid
2. Health Plate placemat
3. Food models
4. What I can eat
5. Serving sizes/food groups
6. Food Packages
7. Fast food nutrition values
8. Nutrients

Length of Class: 50 minutes

Outline:

1. What are the benefits of healthy eating?
2. What is a nutrient?
3. How does exercise affect our body fat?
4. Health problems from unhealthy eating
5. Health benefits from healthy eating
6. What is a healthy plate?
7. What are combination foods and why are they good for me?
8. What's on a food label and what does it mean to me?
9. Why is a food journal important?

Aromatherapy and Reflexology

Objectives:

- Identify the benefits of reflexology during pregnancy
- Identify the benefits of aromatherapy and how different scents affects moods
- Explain the effects of music therapy
- Describe the effects of Reiki

Materials:

1. Music reference list
2. Herbal scents in organza pouches
3. Herbal reference list
4. Sleep mask
5. Lavender-scented lotion
6. Relaxation CD

Length of Class: 50 minutes

Class Discussion:

1. What is the history of reflexology?
2. How does it work?
3. Will it work for me?
4. How do individual scents affect me? Sad? Happy? Relaxed?
5. How does music affect my moods?
6. What is Reiki?
7. How can I use Reiki in my daily life?

Tobacco Use in Pregnancy

Objectives:

1. Identify the health risks associated with smoking
2. List the specific risks of smoking during pregnancy
3. Describe the risks of second-hand smoke to self as well as children
4. Describe ways to decrease second-hand smoke exposure
5. List smoking cessation methods

Materials:

1. Smoking and My Baby brochure
2. Helpline information
3. Websites: www.helppregnantsmokersquit.org
   www.becomeanex.org
4. Stress balls
5. Laundry bag with detergent

Length of Class: 50 minutes

Class Discussion:

1. What are the health risks associated with smoking?
2. What are the health risks if I am pregnant?
3. What are the health risks of second-hand smoke to me and my baby?
4. How can I prevent second-hand smoke around me, my baby, and family members?
5. What methods are available to help me stop smoking?

Childbirth Preparation

Objectives:

- List the signs of preterm labor
- Discuss the types of deliveries
- Discuss pain management options during labor and delivery

Materials:

1. Injoy Video Childbirth2 – Labor, Cesarean birth, epidural
2. Planning childbirth
3. Signs of preterm labor
4. High blood pressure in pregnancy
5. Personal care kit
6. Pregnancy timeline – How to time contractions
7. Postpartum depression

Length of Class: 50 minutes

Class Discussion:

1. What is my “due date?”
2. Why is my “due date” important?
3. What is preterm labor?
4. Can I prevent preterm labor?
5. What is considered high blood pressure during pregnancy?
6. What happens to me when my blood pressure is high?
7. Can I prevent high blood pressure in pregnancy?
8. Can I choose the type of delivery?
9. Can I choose the type of pain medicine during labor?

Family Planning

Objectives:

- Discuss the various birth control methods
- Discuss the birth control myths
- Discuss the effectiveness and failure rate of each method
- Describe available family planning services

Materials:

1. Birth control options booklet
2. Birth control education kit
3. Men's health brochures
4. Women's health brochures
5. STI brochures
6. Condoms

Length of Class: 50 minutes

Class Discussion:

1. What's the best birth control method for me?
2. What's the safest birth control method if I am taking other medicines?
3. What's the safest birth control method that provides the longest protection?
4. Which birth control methods protect against sexually transmitted infections (STIs)?
5. Where can I obtain my birth control?
6. Do I qualify for free or low cost birth control?
7. If I have older children (teens), can they obtain family planning services?
8. Where can my partner go to receive male health services?
9. If I have had a tubal ligation, can I still receive family planning services?

Intimate Partner Violence

Objectives:

- Discuss the different types of violent behaviors
- Discuss the "Cycle of Violence"
- List the steps for developing a SAFE plan
- Discuss the characteristics of a potential batterer
- List available support resources in your local community

Materials:

1. Poem – "I got Flowers Today"
2. Video – "Home is Where the Hurt Is"
3. Brochure – You Have the Right to be Safe

Length of Class: 50 minutes

Class Discussion:

1. What if my partner only yells at me – is that bad?
2. What if my partner won't let me see my friends or family?
3. What if my partner won't let me work outside of the house?
4. It always seems to be my fault – how can I fix this?
5. Do I always have to have sex with my partner even if I don't want to?
6. Sometimes my partner is very rough during sex – what can I do?
7. It seems my partner hurts me more when I am pregnant – why is that?
8. If I am being abused, does it affect my children?
9. I have been trying to break up with my partner, but I think he/she is following me, calling all the time, trashing my property. What should I do?
10. How can I develop a SAFE plan?
11. Are there certain things I should watch for in a partner?
12. Are there places I can go for help? Places I could stay?

Infant Massage

Objectives

- List the benefits of infant massage
- Describe the rules that will help the massage therapy to be successful
- Demonstrate the massage strokes

Materials

1. Dolls, stuffed animals
2. Grapeseed or almond oil

Length of Class: 100 minutes

Class Discussion:

1. What are the benefits for the parent/caregiver of infant massage therapy?
2. What are the benefits of infant massage therapy for the infant?
3. What are the rules of infant massage?
4. Describe the three types of massage strokes?
5. What is the suggested order for infant massage?

Caring for Your Newborn

Objectives:

- Discuss normal feedings for a newborn
- Describe normal bowel movements for a newborn
- Discuss the immunization schedule for a newborn
- Discuss common illnesses in a newborn
- Explain crying in a newborn
- Discuss safe sleep for a newborn
- Identify the signs and symptoms of postpartum depression
- Discuss the Baby Moses Project

Materials:

1. Baby mannequin
2. Bathing equipment
3. Water temperature tester
4. Diaper
5. Bulb syringe
6. Thermometer
7. Bottles with nipples, formula, pacifiers
8. Shaken Baby brochure
9. Safe Sleep brochure and door hanger
10. Babysitter/Caregiver checklist
11. Immunization schedule
12. Infant Bowel Movement handout
13. Caring for your Newborn booklet

Length of Class: 50 minutes

Class Discussion:

1. How often should I feed my baby?

2. How often should my baby have a bowel movement and what should it look like?

3. When should I start my baby's immunization and why are immunizations important?

4. What are some of the common illnesses in a newborn and what are the signs and symptoms?

5. Why does my baby cry so much – am I a bad mother?

6. How and where should my baby sleep?

7. What is postpartum depression and what should I look for?

8. Who should I call if I start to feel like I want to hurt my baby?

9. What is the Baby Moses Project?

Infant CPR and the Choking Infant

Objectives:

- Discuss signs of life threatening breathing/cardiac problems
- Demonstrate how to perform infant CPR
- Identify common choking hazards for infants
- Demonstrate how to rescue a choking infant

Materials:

1. CPR dolls
2. Baby lungs/mouth bags
3. CPR video
4. CPR magnet
5. CPR handout
6. Choking handout

Length of Class: 50 minutes

Class Discussion:

1. What are the reasons a baby would need CPR?
2. What are the danger signs that my baby is having trouble breathing?
3. What is the first thing I should do if I think my baby is not breathing?
4. How do I open the airway?
5. How forceful should I breathe into my baby's mouth?
6. Where should I place my fingers on my baby's chest and how fast should the compressions be?
7. What are some of the common choking hazards?
8. What are the signs of a baby choking?
9. How do I rescue a choking baby?

Neonatal Abstinence Syndrome (NAS)

Objectives:

- Define NAS
- Discuss the differences between heroin and methadone withdrawal
- Discuss the Finnegan Neonatal Abstinence Scoring Tool and its use in the care of babies with NAS
- List the signs and symptoms of NAS
- Discuss treatment options for NAS

Materials:

Finnegan Neonatal Abstinence Scoring Tool

Length of Class: 100 minutes

Class Discussion:

1. How does my baby act when he/she is withdrawing from methadone?
2. How long does it take for my baby to withdraw?
3. What causes my baby to cry so much?
4. How do you measure my baby's symptoms?
5. What do the scores mean?
6. What medicine do you give my baby?
7. How does the medicine work?
8. How long will my baby need to take the medicine?
9. Are there other things that I can do to help my baby feel better?
10. How long will my baby have to stay in the hospital?
11. What do I need to know when I am visiting my baby?
12. What can I do to help my baby stay calm?
13. Who can I talk to about my baby's care?
14. What kinds of things do I have to learn before my baby goes home?
15. Do I have to do anything special when my baby goes home?

Breastfeeding

Objectives

- Discuss the benefits of breastfeeding.
- Discuss challenges to breastfeeding a baby exposed to methadone may experience and ways to intervene.
- Identify different breastfeeding positions.
- Identify signs of correct/incorrect latch.
- Discuss the concept of supply and demand.
- Identify how to tell if baby is getting enough to eat.
- Identify when it is time to pump.

Materials

1. Challenges to Breastfeeding in Methadone-Exposed Infants.
2. Breast Pump(s)

Length of Class: 100 minutes

Class Discussion:

1. Can I breastfeed if I am taking methadone?
2. How much methadone passes through my breast milk to my baby?
3. Is it helpful to my baby if I breastfeed?
4. Why is skin to skin contact so important?
5. What is colostrum and why is it so important for my baby?
6. How often should I breastfeed?
7. Can I breastfeed and bottle feed at the same time?
8. If I have taken other drugs besides Methadone, can I still breastfeed?
9. What positions work better for breastfeeding?
10. What if I don't have big breasts?
11. How do I know if my baby is getting enough breast milk?
12. How long should I breastfeed on each breast?
13. Will breastfeeding hurt?
14. If I decide to stop breastfeeding, are there any risks to my baby?

Child Safety Seat 101

Objectives:

- Discuss the different types of crashes
- Discuss the different types of car seats
- Describe how a child develops and which type of car seat to use
- Identify common mistakes when choosing and installing car seats
- Discuss the importance of using seat belts when pregnant

Materials:

1. Child Safety Seats – Infant, Convertible, Combination, Booster Seats
2. Variety of after-market products
3. Pool noodles
4. Locking clip
5. Rolled blankets
6. Latch bar
7. Local resources for assistance with installing car seats
8. Health for Women Packets

Length of Class: 50 minutes

Class Discussion:

1. What does weight X speed mean?
2. Can my children share a seat belt?
3. Where is the safest position in my car for the child safety seat?
4. What direction should my infant face – rear or forward – and why?
5. Why is it important for me to wear my seat belt while I'm pregnant?
6. What is the retainer clip and where should it be placed on my baby?
7. How tight should the harness straps be and where should they be placed?
8. Can I place a rear facing seat in front of an airbag?

Home Safety

Objectives

- Identify existing and potential hazards within homes for children
- Describe methods of decreasing accidents related to home injury
- Identify resources in the community to assist in protecting the home

Materials

1. Hazard pictures – kitchen, bathroom, living room and bedroom
2. Smoke detector
3. Balloons – mylar, latex
4. Bibs – Velcro/snaps/ties
5. Window blinds cord/cleats
6. Window guards
7. Edge protectors
8. Slip guard material
9. Furniture anchors
10. Toilet locks
11. Chemical solutions
12. Cabinet locks
13. First aid kit, list
14. Emergency preparedness checklist
15. Poison handouts – bites/stings, poisonous plants, poison magnet
16. Home safety brochure

Length of Class: 100 minutes

Class Discussion:

1. Why are smoke detectors so important and where should they be installed?

2. What is the difference between Mylar balloons and latex balloons?

3. What is the safety benefit of Velcro bibs?

4. Why are furniture anchors important?

5. What should I do in a disaster? What papers are important? What do I do with pets?

Shaken Baby Syndrome/Safe Sleep

Objectives

- Describe Shaken Baby Syndrome
- Discuss the injury pattern of Shaken Baby Syndrome
- Explain what *will not* cause Shaken Baby Syndrome
- Describe the characteristics of the person who would shake a baby
- Explain why babies cry
- Describe the “Period of Purple Crying”
- Describe SIDS
- Discuss the safest sleeping position
- Describe what a safe sleep bed looks like
- Discuss when I should use a pacifier
- Discuss what measures can help prevent SIDS
- Discuss “Tummy Time”

Materials

1. Video – Shaken Baby Syndrome
2. Shaken Baby Handout
3. Safe Sleep Brochure, door hanger
4. What does a safe sleep bed look like?
5. Safe sleep brochure for grandparents

Length of Class: 100 minutes

Class Discussion:

1. What is Shaken Baby Syndrome?
2. What Shaken Baby Syndrome is not?
3. What age group is most likely to be shaken?
4. Who would most likely shake a baby?
5. What causes a person to shake a baby?
6. What happens when someone shakes my baby?

7. How do I know if my baby has been shaken?

8. What makes my baby cry?

9. What is the “Period of Purple Crying?”

10. What can I do to prevent Shaken Baby Syndrome from happening?

11. What is SIDS and what are the causes?

12. What can I do to help prevent SIDS?

13. What does a safe sleep area look like?

14. Why can’t my baby sleep with me?

15. What is “tummy time?”

16. Who needs to know about my desire to have my baby sleep on his back?

Developmental Milestones and Age Appropriate Discipline

Objectives

1. Describe some reasons for crying or “acting out.”
2. Discuss calming techniques for when a baby won’t stop crying or “acting out.”
3. Discuss developmental expectations from birth to 18 months.
4. Describe age appropriate behaviors.
5. Discuss ways to increase desirable behaviors.
6. Describe coping skills to prevent losing control around children.
7. Describe physical punishment.
8. Discuss negative side effects from physical punishment.
9. Discuss limit setting.
10. Discuss healthy ways to deal with anger.

Materials

1. Handout from Dando Fuerza a la Familia parenting curriculum

Length of Class: 100 minutes

Class Discussion:

1. What are some reasons that a baby would cry?
2. What can I do if my baby is crying?
3. What can I do if my baby won’t stop crying?
4. What is normal behavior for a baby (age appropriate)?
5. What can I do to increase the good behaviors?
6. What can I do to help decrease bad behaviors?
7. What is physical punishment?
8. What are some negative consequences of physical punishment?
9. What can I do instead of physical punishment?
10. How can I deal with anger in a healthy way?

Social Services and Child Protective Services (CPS) Liaison

Objectives

- Describe the resources available through Social Services
- Discuss CPS referral criteria
- Identify ways to improve outcomes for me and my baby
- Identify my social and family support system
- Outline a safety plan

Length of Class: 50 minutes

Class Discussion:

1. What type of help is available through Social Services?
2. What is the role of Social Services when I have my baby?
3. What type of information will the social workers ask for or look for?
4. Why would CPS be called?
5. Are there rules/laws that guide when CPS is called?
6. Is there a referral on every mom who is taking methadone?
7. What can I do to improve the NICU process?
8. What if I test positive for other drugs?
9. What is a safety plan?
10. What are the requirements for someone else to take my baby home?
11. Do I have to stop taking methadone to take my baby home?

Frequently Asked Questions

Q: How many *Mommies* on average, complete the program?
A: *Approximately 70% of the women each year who enroll in the program complete it.*

Q: How many *Mommies* return for services*?***
A: *Approximately 30% of Mommies return for services.*

Q: Can *Mommies* participate in the program more than one time?
A: *Yes, Mommies are encouraged to return if they feel they need services or support.*

Q: Where are *Mommies* typically referred for services once they complete the *Mommies* Program?
A: *Most of the Mommies are also engaged in services with other programs such as medication assisted treatment (MAT). We can make referrals to local agencies that provide family counseling, self-help groups, 12-step groups, and religious programs/services when appropriate.*

Q: What have been the biggest obstacles in operating this integrated program?
A: *Communication and maintenance of boundaries. Having open communication at all times helps community partners stay focused and allows them to gently remind one another of goals and mutually agreed upon boundaries.*

Q: How do community partners maintain a sense of collaboration and cooperativeness?
A: *In the beginning/inception phase of the program weekly meetings are essential for establishing a collaborative relationship and ensuring good communication between the partners. These meetings can eventually be moved to bi-weekly and then monthly as progress is made. It helps to provide a consistent meeting schedule that is honored by all partners.*

Q: What if we don't have all of the services the Restoration Center in San Antonio offers?
A: *Begin with what you do have available and then start to explore additional funding sources or agencies in your community that can assist you. Initially, the Mommies Program had a few partnerships that we slowly built upon over time to offer more services. For example, in the beginning we had a local domestic violence agency come*

in to provide that service for the Mommies, but over time we were able to provide our staff with the necessary training. They are now able to provide these services without an outside agency assisting them.

Q: What would you suggest we do to offer all of the services offered by the Mommies Program?
A: *Begin with the most immediate/basic services and then add to these services in increments over time. Slowly build the program so it is tailored to meet the needs of your consumers and the community.*

Q: Does this program have a shared budget or does each partner manage their own budget? In other words, does either CHCS or University Health System employ and pay for all the key positions in the program?
A: *University Health System provides funding for the CHCS to offer services and operate the Mommies Program. The staff are actually CHCS employees. University Health* System *and CHCS have a signed Memorandum of Understanding to provide this funding that is renewed annually.*

Q: What kind of budget does this program require to operate?
A: *Based on the size of program and the number of women and children who are served, the budget can range anywhere from $175,000-$400,000. This includes salaries, fringe benefits, patient transportation costs, materials, incentives supplies, vehicle operating costs, etc.*

Q: What do you suggest should be the first step in finding a partner to respond to the RFP (request for proposal) with and ultimately develop an MOU (memorandum of understanding)?
A: *Reach out to community partners that serve the same target population and provide services that would further enhance your existing services. Setting up meetings at the upper management level to discuss partnerships is very important. Also, begin by building collaborations with partners you are already working with and whose services and mission you know.*

Q: Is there anyone in the Mommies Program that can offer guidance as we get started? Or, how do we get technical service as we attempt to build our own integrated programs within our community?
A: *Follow-up technical assistance is being offered to health districts in Texas. The point of contact for assistance is Dr. Lisa Cleveland at clevelandl@uthscsa.edu*

Forms

Consent Template

CMBHS
Clinical Management for Behavioral Health Services

Consent

Client Information

Client Name	
Client Number	
Client Date of Birth	MM/DD/YYYY

Discloser

By signing this Authorization, I am giving permission to use and disclose records about me as described below

I authorize the following entity to disclose my health information in accordance with this Authorization:	

Disclosee

I authorize use by or disclosure of my health information to the following entity:	

Expiration Date

This Authorization expire on following date if not properly revoked earlier	MM/DD/YYYY

Health Information to be Disclosed

All Records	☐		
Records for Specific Dates	☐		
Records Obtained From Other Providers	☐	Begin Date	MM/DD/YYYY
		End Date	MM/DD/YYYY

CMBHS Help Desk: 1-866-806-7806

General Records	☒ Client Profile ☐ Financial Eligibility		
Substance Abuse Records	☐ Admission/Discharge	☐ Assessments	☐ Begin/End Services
	☐ Discharge Follow-up	☐ Medications	☐ Residential Services
	☐ Discharge Plan	☐ Discharge Summary	☐ Lab/Test Results
	☐ Notes	☐ Open Case/Close Case	☐ Referrals
	☐ Screenings	☐ Wait List Entry	☐ Treatment Plans
	☐ Service Requests/Authorizations	☐ Treatment Plan Reviews	☐ Other
Mental Health Records	☐ MH Diagnosis ☐ MH Assessments		

Purpose of Authorization

I authorize the use or disclosure of my health information as set forth in this Authorization for the following purposes:	
☐ Payment for my services from a third party payer	☐ Referral to another program or provider
☐ Continuity of Care	☐ Criminal Justice Purpose
☐ Health Oversight Activities	☐ Other

Signatures

Party other than client is signing the authorization	○	**The person listed below is legally authorized to use or disclose the health information for the client identified in this authorization**	

I understand that my eligibility for services cannot be conditioned upon my signing this Authorization; however, services to be paid for by any third party are conditioned upon my signing this Authorization for disclosure to the third party when Authorization is required by law or for payment purposes. I am not guaranteed services on the basis of this Authorization. My health information may be protected under federal and state laws and may not be disclosed without my signed Authorization, unless otherwise provided for by state or federal law. Even if I refuse to sign this Authorization, my health information may be used or disclosed without this Authorization when allowed or required by law. Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected under HIPAA.

I also understand that I may revoke this Authorization in writing to this provider at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires in accordance with the conditions specified in this document.

This Authorization cannot be revoked if the use or disclosure is required for payment to this provider for services provided in reliance on this Authorization.

Client Signed	○	Client Name	Signature Date MM/DD/YYYY

Mommies Satisfaction Survey (English) Template

(Name of Integrated Program)
Satisfaction Survey

Name (OPTIONAL): _____ Date: _____

Please share your feedback about the services you received in the (Name of Program) by rating the following items using the scales provided. This information will be used to help us make improvements to the services we offer. You do NOT have to provide your name and all responses will remain anonymous.

1. The services I received were delivered in a non-judgmental manner.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

2. The services I received were focused on my individualized needs.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

3. The providers/agencies involved in my treatment worked together as a team.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

4. The services I received improved my life.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

5. I would recommend the (Name of Program) to others.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

6. Overall, the services I received were:

Very Good	Good	Fair	Poor	Very Poor

Comments:

_____
_____
_____
_____

If you have any questions regarding the (Name of Program) or this survey, please contact (Program Director's Name) at (XXX-XXX-XXXX) or XXX@XXX.XXX. Thank you for your feedback!

Mommies Satisfaction Survey (Spanish) Template

(Nombre del Programa Integrado)

Encuesta de Satisfacción

Nombre (OPCIONAL): _____ Fecha: _____

Por favor comparta su opinión acerca de los servicios que recibió en el (Nombre del Programa) dando un puntaje a las siguientes afirmaciones usando la escala suministrada. La información será usada para ayudar a mejorar los servicios que ofrecemos. Usted NO tiene que dar su nombre y todas las respuestas permanecerán anónimas.

1. Los servicios que recibí fueron dados sin hacer juicios. .

Muy de Acuerdo	De Acuerdo	Ni de Acuerdo ni en Desacuerdo	En Desacuerdo	Muy en Desacuerdo

2. Los servicios que recibí se enfocaron en mis necesidades individuales.

Muy de Acuerdo	De Acuerdo	Ni de Acuerdo ni en Desacuerdo	En Desacuerdo	Muy en Desacuerdo

3. Los proveedores/agencias involucrados en mi tratamiento trabajaron en equipo.

Muy de Acuerdo	De Acuerdo	Ni de Acuerdo ni en Desacuerdo	En Desacuerdo	Muy en Desacuerdo

4. Los servicios que recibí mejoraron mi vida.

Muy de Acuerdo	De Acuerdo	Ni de Acuerdo ni en Desacuerdo	En Desacuerdo	Muy en Desacuerdo

5. Yo le recomendaría (Nombre del programa) a otras personas.

Muy de Acuerdo	De Acuerdo	Ni de Acuerdo ni en Desacuerdo	En Desacuerdo	Muy en Desacuerdo

6. En general, los servicios que recibí fueron:

Muy Buenos	Buenos	Más o Menos	Malos	Muy Malos

Comentarios:_____
_____
_____
_____

Si usted tiene alguna pregunta acerca de (Nombre del programa) o esta encuesta, por favor contacte a (Director del programa) al (XXX) XXX XXXX o XXXX@XXX.XXXX. ¡Gracias por su opinion!

Websites

Journeys of Hope: Mommies and Babies Overcoming NAS

Stronger Together: NAS Soothing Techniques for Mommies and Babies

Lactation Matters: Official Blog of the International Lactation Consultant's Association:

Substance Use Disorders in Pregnancy and Lactation: What IBCLCs Need To Know

Other Resources

STATE RESOURCES

1. **Texas Department of State Health Services (DSHS)**

- **(512) 776-7111** or **1-888-963-7111** (FREE)
- https://www.dshs.state.tx.us/

2. **Health and Human Services Commission (HHSC)**

- **2-1-1** or **1-877-541-7905** (FREE)
- http://www.hhsc.state.tx.us/
    - **Housing and Shelter Resources in Texas**: https://www.211texas.org/cms/search-housing-shelter-services-in-texas
    - **Food Assistance Resources in Texas:** https://www.211texas.org/cms/search-food-resources-in-texas
    - **Financial and Legal Assistance in Texas:** https://www.211texas.org/cms/search-financial-legal-services-in-texas
    - **Health Related Resources in Texas:** https://www.211texas.org/cms/search-health-services-in-texas
    - **Mental Health Services in Texas:** https://www.211texas.org/cms/search-mental-health-services-in-texas

3. **Outreach, Screening, Assessment and Referral Centers (OSAR):**

- **1-877-9-NO DRUG (1-877-966-3784)** or **1-877-966-3784** (FREE)
- https://www.dshs.state.tx.us/sa/OSAR/

4. **United Way of Texas:**

- **(512) 651-1149**
- http://www.uwtexas.org/

5. **Salvation Army Texas:**

- **(214)-956-6000**
- http://www.salvationarmytexas.org/

6**. Society of St. Vincent de Paul**:

- https://www.svdpusa.org/

SAN ANTONIO AREA RESOURCES

1. **University Health System:**

- **(210) 358-4000**
- http://www.universityhealthsystem.com/

2. **Center for Healthcare Services (CHCS):**

- **210-261-1000**
- http://www.chcsbc.org/

3**. San Antonio Council of Alcohol and Drug Abuse (SACADA):**

- **(210) 225-4741**
- http://www.sacada.org/

4. **Haven for Hope:**

- **Main line: (210) 220-2100**
- **Help line: (210) 220-2357**

- **After hours: (210) 261-1484**
- http://www.havenforhope.org/new/

5. **Alamo Area Resource Center:**

- **(210) 625-7200**
- http://www.aarcsa.com/

6. **Society of St. Vincent de Paul**:

- **210-225-SVDP (7837)**
- http://www.svdpsa.org/Pages/Home/Home.asp

6. **VIA:**

- **(210) 362-2020**
- http://www.viainfo.net/Ride/Default.aspx